YOUR RIGHT TO APPEAL YOUR MEDICAL INSURANCE PAYMENT

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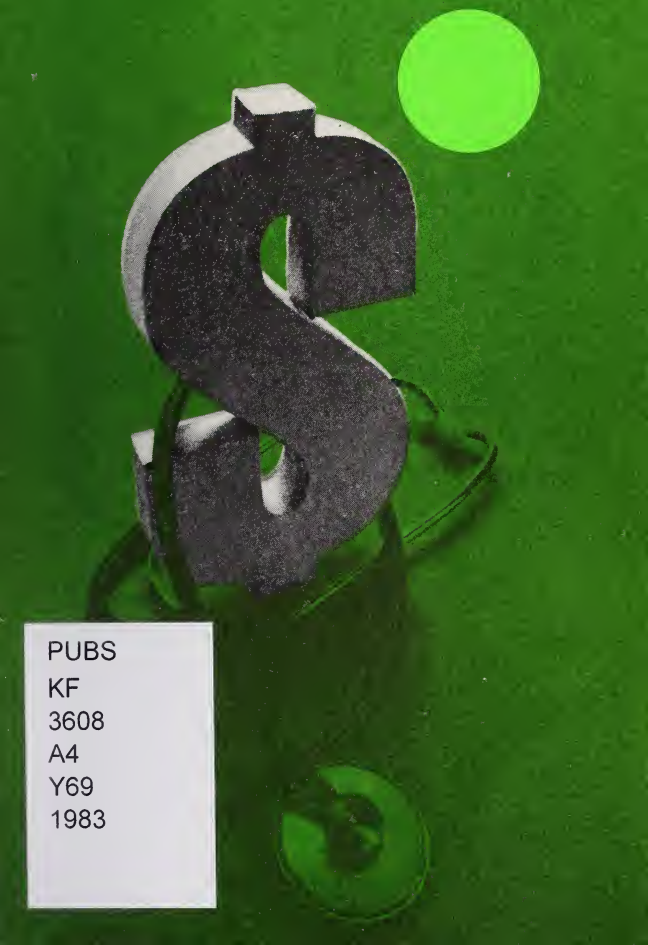

Your right to appeal your medical insurance payment

Claims for payment under the medical insurance part of Medicare are handled by Medicare carriers. The carrier is an insurance organization under contract with the Federal Government.

When a claim is submitted, the carrier first examines it to determine if the services are covered by medical insurance. Then the carrier determines the "approved" charges for such services. (For an explanation of how "approved," or "reasonable," charges are figured, please read the chapter on "Approved charges" in *Your Medicare Handbook*. If you don't have a handbook, you can get one from any Social Security office.

If the carrier decides that some or all of the services are not covered or that the charge for the services is more than the approved amount, it may either deny the claim or make payment on the basis of the approved charge. The carrier will notify you of its decision and the reasons for the decision.

If you disagree with the carrier's decision to disallow all or part of your claim, you can appeal the decision. This leaflet describes the steps you may take. **These steps apply only to medical insurance claims.** Different rules apply

to Medicare hospital insurance claims. You can get a copy of the leaflet *Your right to appeal decisions on hospital insurance claims* at any Social Security office.

An important note

The carrier is required by law to make an initial decision on medical insurance claims with reasonable promptness. If it does not take action within 60 days from the time you file your claim, you may request a hearing. Your request may be made directly to the carrier or through a Social Security office.

STEP 1: Request a review

If you disagree with the decision on your claim, you may ask the carrier to review it.

A request for review must be made within 6 months of the date of the notice of the initial decision.

The request must be in writing. It should show your name and health insurance claim number and the reasons you disagree with the decision. It also should include any claim number and/or control number which was shown on the notice of decision or *Explanation of Medicare Benefits* sent to you by the carrier. If you have additional evidence to support your claim, you should submit it with your request.

You may send your request either to the carrier that handled your claim or to a Social Security office, which will forward it to the carrier.

The carrier will examine all the evidence to determine if the original decision was correct. This review is not made by the person who made the original decision, but by another qualified person.

You do not personally appear before the carrier. The review is based only on the written documents in file.

A notice of the review decision will be mailed to you.

STEP 2: Request a hearing

If you still disagree with the decision on your claim after it has been reviewed, you may request a hearing. You will be entitled to a hearing **only** if the difference between Medicare's approved charge (minus any deductible and coinsurance) and the actual bill for services is at least $100. To meet the $100 minimum, you can count other claims that you have had reviewed within the past 6 months.

A request for a hearing must be filed within 6 months of the date you receive the notice of review decision. You can send the request to the carrier that handled your claim or to a Social Security office for forwarding to the carrier.

The request must be in writing. It should show your name and health insurance claim number and give the reasons you disagree with the review decision. Be sure to also include any claim number which was shown on the notice of review decision. You may submit any additional evidence that you want to have considered.

You will be notified of the place, date, and time of the hearing. You may appear personally at the hearing, and you may have someone represent you if you choose.

The hearing is conducted by a hearing officer appointed by the carrier. The hearing officer will not have been involved in the previous decisions made on your claim. He or she will review what has already happened in the case, state what must be decided, and ask questions of you and any witnesses present. The hearing officer may ask a witness for the carrier to attend the hearing to explain how the carrier arrived at its decision. You and your representative may question the witnesses, present new evidence, and examine the evidence on which the hearing officer will base his or her decision.

You do not have to appear at the hearing. If you don't, the hearing officer will base his or her decision on the written evidence which was previously submitted in the case plus any additional written evidence or statements.

A copy of the hearing officer's decision will be sent to you. The decision of the hearing officer is final. The law does not provide for further review of medical insurance claims.

Your right to be represented

You have a right to be represented at any stage of your claim for medical insurance payment. Your representative may be an attorney, a relative, or any other qualified person you choose. You are responsible for paying any fee your representative may require.

For more information

If you have any questions about your right to appeal a decision on your medical insurance claim, call any Social Security office or your Medicare carrier. The people there will be glad to help you.

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